DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 1 4

2. STATE: UTAH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~JUNE 17~~, 2003 July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SECTION 1902 (a) (13) (A)

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ Ø
b. FFY 2004 $ Ø

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-A Pages 10 and 11a (1)
11a (2), 11b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 4.19-A Page 10

10. SUBJECT OF AMENDMENT:
INPATIENT HOSPITAL / DISPROPORTIONATE SHARE SHOSPITAL

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF ~~STATE AGENCY~~ OFFICIAL:
Rod L Betit

13. TYPED NAME:
ROD L. BETIT

14. TITLE:
EXECUTIVE DIRECTOR, UTAH DEPARTMENT OF HEALTH

15. DATE SUBMITTED:

16. RETURN TO:
ROD L. BETIT
UATH DEPARTMENT OF HEALTH
PO BOX 143102
SALT LAKE CITY, UT 84114-3102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
July 7, 2003

18. DATE APPROVED:
August 4, 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPRCVED MATERIAL:
JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis G Smith

21. TYPED NAME:
DENNIS G. Smith

22. TITLE:
DIRECTOR, CMSO

23. REMARKS:
Pen & ink changes to blocks 4 & 8

POSTMARK: July 2, 2003

INPATIENT HOSPITAL
Section 400 Adjustments for Disproportionate Share Hospitals

409 Introduction C This section establishes criteria for identifying and paying disproportionate share hospitals (DSH). For the purpose of paying disproportionate share hospitals, there are six types of hospitals: first, private hospitals licensed as general acute hospitals located in urban counties; second, general acute hospitals located in rural counties; third, the State Psychiatric Hospital; fourth, the State Teaching Hospital; fifth, children=s hospital; and sixth, frontier county hospitals in economically depressed areas.

410 Definitions C For purposes of this section, the following definitions apply:

A. Medicaid Inpatient Utilization Rate (MIUR) is the percentage derived by dividing Medicaid hospital Inpatient days (including Medicaid managed care inpatient days) by total inpatient days.

B. Low Income Utilization Rate (LIUR) is the percentage derived by dividing total Medicaid revenues (including Medicaid managed care revenues) plus UMAP revenues by total revenues and adding that percentage to the percentage derived from dividing total charges for charity care by total charges.

C. Indigent patient days is the total of Medicaid patient days (including managed care days) plus UMAP/PCN (see description in section D which follows) patient days and other documented charity care days.

D. UMAP/PCN is a term used to describe the is the Utah Medical Assistance program and its successor program (PCN) Utah Primary Care Network plan operated for low income (indigent) recipients. The PCN became effective on July 1, 2002.

E. Uncompensated Care means the amount of non reimbursed costs written off as non recoverable for services rendered to the uninsured, i.e., indigent, and includes the diference between cost of providing services to those eligible for medical assistance under the State plan and the payment for those services by the State by Medicaid or any other payer.

411 Obstetrical Services Requirement C Hospitals offering non-emergency obstetrical services must have at least two obstetricians providing such services. For rural hospitals, an Aobstetrician@ is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital. This requirement does not apply to children=s hospitals nor to hospitals which did not offer non-emergency obstetrical services as of December 22, 1987.

412 Minimum Utilization Rate C All DSH hospitals must maintain a minimum of 1% Medicaid Inpatient Utilization Rate.

INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

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419 Depressed Frontier County Hospitals C Rural government owned hospitals, which can establish that they meet all of the following conditions, will qualify for additional DSH payments:

- Is in an economically depressed area as determined by State and Federal definitions;
- Is a sole community provider as defined in '413E of the State Plan Of Utah;
- Has less than 30 acute (not including nursery) licensed beds ***(based on current licensor)***;
- Has a Medicaid census that totals a minimum of 33% of all patient (non nursery) days of service provided ***(based on last completed hospital fiscal year)***;
- Exhibits a population density of one-third of the population density qualification level necessary to qualify as a frontier area (that is, an area with fewer than two* residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets the criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act.

Payment of this additional DSH payment will be $1,000,000.00 per year (including both state and federal share and the uncompensated care that the hospital experiences, which ever is less. Any participating hospital(s) will be entitled to its pro rata share of this amount depending on its relative percentage of documented Auncompensated care@ when compared to all applying hospitals on a relative basis.

For example: Hospital A and Hospital B meet all qualifying criteria as mentioned above. Hospital A has $600,000.00 in uncompensated care and Hospital B has $400,000.00 in uncompensated care. These two hospitals will therefore share the allocated DSH of $1,000,000.00 according to the following –

	Uncompensated Care	*Uncompensated Care %*	*Share of Augmented DSH*
Hospital A	*$600,000.00*	*60%*	*$600,000.00 (60% of $1,000,000)*
Hospital B	*$400,000.00*	*40%*	*$400,000.00 (40% of $1,000,000)*

* Population density to qualify as a frontier area is currently at 6 persons/sq. mile. One third of this is 2 persons/sq. mile.

INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

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421 Method and Timing of DSH Payments C Each claim for payment to qualified providers includes a percentage add-on at the level specified for that facility. Each quarter the total amount of DSH to all qualified facilities is calculated. The amount, along with any preceding quarters for the current fiscal year, is used to predict the total amount that will be paid. If this exceeds the current DSH allotment, the payment level will be adjusted in order to correct for any potential overpayment. This adjustment will be applied to all hospitals proportionally, except for Children=s hospital which will not be adjusted below the base year (see section 418). The state reserves the option to dispense funds via a lump sum payment should the need arise. This could occur where claims volume is not the best method or base upon which to distribute a special DSH payment; ***specifically the additional DSH afforded to hospitals meeting the criteria of '419, above, will be paid quarterly.***
The percentage "add-on" for a facility is computed by the following formula:

(Facility's Medical Assistance Days as a % of the facilitys total days (for prior year))
x (Yearly Qualifying factor (which for 2004 is 2.01%))
x (Facility's Medicaid payments)
x .12 per $1.00 (payment equalization factor for 2004 = Facility's % "add-on" for the year.
This is rounded to the next highest %.

For example: Hospital A has the following hospital specific information:
Facilities medical assistance days: 100
Facilities Total days:200
Yearly Qualifying Factor: 2.01%
Total Yearly medical assistance payments: $100,000.00
Payment equalization factor: 12% per $1.00
This is rounded to the next higher % (with a ceiling of 4%)

The percentage "add on" percentage is therefore the following:

(100/200) x (2.01%) x ($100,000.00) x (.12/$1.00)= 1.21% rounded to 2%

AUG 3 1 2004

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INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

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501 General – Because of the wide variation in the length of stay for rehabilitation services under DRG 462, there is a need to refine the DRG criteria. Rehabilitative services under DRG 462 are subdivided into five groups. Each group has an established average length of stay and a base payment calculated in accordance with Section 122 of Attachment 4.19-A. Payments are made for outliers above the designated threshold consistent with other DRG payments.

510 Designated Groups – Rehabilitation is subdivided into the following groups: (1) Spinal – Para; (2) Spinal – Quad; (3) Head; (4) Stroke; and (5) Other. "Spinal—Para" includes patients with paraplegia who require an initial intensive inpatient rehabilitation program. "Spinal –Quad" includes patients with quadriplegia who require an initial intensive inpatient rehabilitation program. "head" includes patients with head trauma and with documented neurological deficits who require an initial intensive inpatient rehabilitation program. "Stroke" includes patients

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